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Treatment Trends

A NEWSLETTER OF TAYLOR MANOR HOSPITAL

SELF-MUTILATION: THE SYMPTOM AND ITS MANAGEMENT

By Lois M. Conn, M.D.

Not all self-mutilation is a reflection of psychopathology. Tattooing, body scarring, lip, nose and ear piercing, and foot binding are just some of the practices that are performed throughout the world as part of religious beliefs or fashion. Within specific cultures, they are accepted.

Self-mutilation which grows out of psychopathology is another matter.

While self-injury necessitating psychiatric intervention is relatively uncommon, it is certainly not rare. The phenomenon occurs in about one percent of the general population and in three to five percent of psychiatric patients. It takes many forms, and explanations for its occurrence are nearly as numerous.

Patients injure themselves in order to ease tension, to resolve internal conflicts, or to decrease feelings of emptiness, depersonalization or unreality. They mutilate themselves in response to psychotic thinking manifested by command hallucinations or delusions, or because of a belief that in order to preserve themselves for a higher spiritual good, a sacrificial act such as castration or eye removal must be performed. Self-mutilation may be carried out for secondary gain, as with prisoners who injure themselves in order to get out of prison and into a hospital setting. It can be done to inflict guilt on others, as an act of self-punishment or atonement, or to gain control of one's own body. It is rarely an actual suicide attempt.

In most cases, the goal of mutilation is the act itself, not death. Even in the most serious forms of self-mutilation we usually find that precautions are taken in order to preserve life.

The level of seriousness of self-mutilation usually depends upon the severity of the patient's pathology. Patients with anxiety disorders

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Treatment Trends is one of a series of new publications produced by Taylor Manor Hospital for mental health professionals. Each issue will contain important information and interesting articles relating to modern mental health care as it impacts the professionals in the field. Inquiries and comments are welcome. ■

This issue of *Treatment Trends* contains a presentation made as part of Taylor Manor Hospital's Continuing Education Lecture Series. These monthly lectures feature a variety of professionals offering timely topics in their fields of expertise. Taylor Manor Hospital offers these programs without charge to health care professionals. Regular announcements of upcoming lectures will be contained in each Treatment Trends issue. See page three for the current calendar. ■

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(neurotic disorders) may engage in such actions as fingernail and lip biting. Borderline patients most often cut their wrists and burn their skin with cigarettes or caustic agents. Psychotic individuals present the more dramatic kinds of self-mutilation—auto-castration, auto-cannibalism, and organ removal.

Let's look at each type separately.

Neurotic patients generally have no conscious intent to harm themselves. In fact, in describing the self-injury, the neurotic patient may say: "I want to stop and I'm trying to stop, but I can't. Do something to help me stop."

The borderline patient, on the other hand, may recognize that there is a problem, but the act of self-mutilation provides such relief that there is often no real desire to give it up.

A number of psychodynamics underlying neurotic self-harm have been hypothesized. Self-mutilation may represent unexpressed guilt and rage, leading to self-punishment—anger being turned inward and expressed as self-injury. It may satisfy the need to rid the skin of "dirt" and "contamination."

Among borderline patients, wrist-cutting is the most common kind of self-mutilation. Epidemics of wrist-cutting in mental hospitals have been described, especially on adolescent units where one patient's act will precipitate a rash of such incidents.

A number of childhood antecedents of wrist-cutting have been found, although there is no evidence that these events necessarily caused the behavior. The backgrounds of adult wrist-cutters often show maternal deprivation, particularly a lack of handling and skin contact, open parental display of sex or aggression, and such physical traumas as sexual abuse or surgery early in life. In addition, there is frequently a history of eating disorders occurring at some time prior to self-mutilation or in conjunction with it. Obviously, all of these are non-specific features and are present in the backgrounds of many disturbed people.

Numerous motivations for wrist-slashing have been proposed, including punishment of the introjected depriving mother, the need to relieve inner tension and emptiness, attention-seeking, nonverbal communication ("see what you made me do"), a means of dealing with genital conflicts, self-punishment, the expression of an ambivalent suicidal wish, and a way to gain prestige among other wrist-cutters. Many wrist-cutters have been noted to cut themselves in response to separation, perceived rejection, or disappointment in a relationship. What all this seems to tell us is that wrist-cutting among borderline patients is a relatively non-specific way of non-verbally discharging intrapsychic distress resulting from many causes.

In most cases, the goal of mutilation is the act itself, not death.

While self-mutilation can be an attempt to control others, generally it is not. Most self-mutilators act in private and are so ashamed of their actions that they don't present for emergency medical treatment unless absolutely necessary.

The most dramatic occurrences of self-harm are generally associated with schizophrenic and other psychotic disorders. There have been cases of auto-castration, auto-amputation of the digits and limbs, removal of one or both eyes, removal of the tongue, and abdominal self-surgery.

Psychotic self-mutilation differs markedly from neurotic and borderline self-injury. Psychotic patients injure themselves in response to profound disorders of perception or thought and do not recognize the irrationality of their acts. Their self-destructive behavior is generally not stereotyped, chronic or repetitive but is usually characterized by one or several distinct actions which may be bizarre or drastic in form. While the borderline patient will cut, burn or otherwise injure herself in order to relieve general feelings of tension, the psychotic individual usually has specific reasons and acts in a very highly personalized, symbolic way.

The psychotic patient may say, "I sinned. I looked lustfully at my neighbor's wife, so to atone I had to remove my eye." Or, "The CIA was after me and the only way I could escape was to cut off my finger."

As opposed to neurotic or borderline individuals, psychotics often appear outwardly calm both before and during the self-destructive episode. They typically do not feel any pain even in the face of extensive physical injury. It has been suggested that this phenomenon may be due to a dissociation of affect from action, so characteristic among schizophrenic patients.

The psychotic patient may also deny his own role in deciding to hurt himself. He may maintain that he was under control of an outside force or was acting in accordance with a biblical injunction which commanded him to commit the act. The latter reason is seen frequently among those with a high degree of religious preoccupation.

Command hallucinations are very worrisome, and it is important to determine if patients feel they are able to resist them. Concrete religious preoccupations are also a predictor of self-harm, especially if the patient feels controlled by a trusted religious source such as God. If God is "telling" the patient to harm himself, chances are that he will.

Composed patients have been found to be at greater risk than those who

are agitated and seeking relief from turmoil.

There is a high incident of self-mutilation among the mentally retarded with estimates of 10 to 20 percent reported in hospitalized mentally subnormal populations. Self-injury in this population is usually of the repetitive, stereotypical variety, involving such actions as head banging, biting, hair pulling, face slapping and skin pinching. A cardinal feature of Lesch-Nyhan Syndrome is aggressive self-mutilation. Beginning early in childhood, sufferers will bite their lips and fingers with such ferocity that partial amputation of the digits and tissue loss from around the mouth are common. Self-injurious behavior in other organic disorders such as Tourette's Syndrome and encephalitis has also been reported.

Treatment of self-mutilation focuses on protective limit-setting and treating the underlying psychopathology.

Strategies for Psychotherapy

Treatment of self-mutilation focuses on protective limit-setting and treating the underlying psychopathology. Obviously, if the patient's pattern of mutilation presents a danger of serious physical damage or death, hospitalization is called for. Otherwise treatment can usually be conducted on an outpatient basis.

Diagnostically, most self-mutilators fall into the category of Borderline Personality Disorder, and most of these are wrist-cutters.

People who cut themselves usually have extreme difficulty expressing their emotions verbally; action is substituted for words. Rather than talking about their emotional turmoil, and then finding a less disruptive way to achieve relief, they cut.

In treating these individuals, the therapist needs to remain empathically connected to the patient while maintaining the position that the patient is responsible for her own behavior. We should communicate, both verbally and non-verbally, that we cannot stop the patient from harming herself, but that we can help her develop skills for deciding how to behave.

Borderline patients often injure themselves in response to feelings of emptiness, "disconnectedness," anger or rejection, and it is important to help them become increasingly aware of their feelings so as to deal with them in verbal terms. Unfortunately, this approach causes considerable anxiety, especially in the beginning.

Behavioral psychologists tell us that if a person avoids tension reducing activity, the person becomes more anxious. Wrist-cutting reduces tension and when patients avoid it, their anxiety increases. A simple explanation to the patient about this phenomenon may be useful in helping her tolerate the anxiety which develops as she gives up the wrist-cutting behavior. Patients not alerted to the anxiety reaction may find the feeling so unfamiliar and intolerable that they revert to mutilating themselves for relief.

Patients should also be assured that uncomfortable feelings tend to diminish in intensity over time if they are tolerated. Many patients believe that feelings must be discharged immediately through physical action in order to obtain relief. This belief must be overcome if the patient is to learn to express emotions verbally.

Detail in psychotherapy is all-important. The clinician must thoroughly discuss those events which make the patient feel angry, lonely, or rejected, or which create other feelings that lead to self-injury. Affect is associated with detail, not with generalizations, so the goal is to discuss, in detail, events and feelings just preceding the mutilation.

We can help the patient by clarifying, over and over again, the meaning of different feelings. If the patient says, "I was angry," the therapist should work with the patient to reconstruct the anger precisely to determine exactly what made her angry and at what point she was aware of the anger, and how specifically she experienced the feeling. Impulsive patients must learn to recognize and tolerate their various emotional states, then to convert these feelings into verbal expression which is then accepted and clarified by the therapist. In this manner, previously warded-off feelings are gradually accepted by the patient and integrated into her life.

Patients who injure themselves characteristically have an impoverished fantasy life. Encouraging fantasy as part of the psychotherapy allows patients to foresee the consequences of their actions. Also, since carrying out an action in fantasy often leads to a decrease in the urgency of the impulse, the action then doesn't have to be carried out in reality. Fantasizing may provide sufficient emotional release.

Detail in psychotherapy is all-important.

Self-mutilators usually do not think about the injury before it occurs. Their typical reaction is, "I was feeling tense and the next thing I knew I had already cut myself." By teaching

the patient to stop and think about a disturbing event or feeling, time is interposed between thought and action and patients are given "breathing space" to consider the consequence of various behaviors before acting.

Fantasizing the self-mutilation itself should be encouraged, but the fantasy should not stop with the act of cutting. Instead, the patient should be encouraged to fantasize about both the short- and long-term consequences of the behavior. The fantasy should include picturing the trip to the emergency room, the act of suturing, the risk of infection, the possible development of scars, and the feeling of shame that often follows self-injury. By taking the fantasy all the way through, rather than just stopping at the point of emotional release, patients can learn to anticipate the consequences of their actions.

Although countertransference issues have been minimally described in the literature, they play a crucial role in treatment. Anger regarding a self-mutilator's attempt at manipulation of the therapist is very common.

Patients may wish for the therapist to take responsibility for their behavior and may escalate the self-injury in an attempt to obtain this. This is a stressful time for the clinician. The therapist may be tempted to accept the patient's fantasy that the therapist is magically omnipotent, and therefore able to protect the patient from her own self-destructive behavior. It is important to convey an attitude of genuine concern for the patient's distress, while not attempting to assume responsibility for the patient's actions. Self-mutilation is one choice among many for dealing with emotional pain. It is the therapist's job to help the patient explore the various options; the ultimate choice lies with the patient.

With some self-destructive acts, the patient may become disfigured and confront us with fears and anxieties about our own bodies. This can lead to feelings of disgust and revulsion, as well as the feeling that the patient did it to herself and got what she deserved. These counter-transference feelings tend to be defensive on the part of the therapist and serve to distance the clinician from the patient. On the other hand, some self-mutilating patients, especially the younger ones, may evoke rescue fantasies that can lead to over involvement on the part of the therapist, unrealistic expectations for treatment outcome, and a feeling of failure if the behavior doesn't stop right away. Attention to counter-transference feelings and acknowledgement of one's limitations in therapy are important for maintaining a therapeutic climate in which both empathy and optimal distance are maintained.

We can help the patient by clarifying, over and over again, the meaning of different feelings.

Although there are no medications which are specific for the management of self-mutilation, a number of drugs have been used. The first step in treatment is to stop all medications if possible. Chronically self-injuring patients may be on a pharmacopeia of drugs as different approaches are tried, and it is important to initially withdraw all medications in order to get a clearer clinical picture, as well as to reduce the likelihood of drug interactions which may be worsening the behavior. This may best be accomplished in the hospital.

Neuroleptics are obviously useful for patients who are prone to harm themselves in states of psychotic decompensation. The neuroleptic medications, particularly at low doses, have also found some usefulness in the treatment of borderline patients. Occasionally, antianxiety medication may be helpful if the self-mutilation grows out of a high level of tension and anxiety. It is important to remember that most of the antianxiety medications are addictive and since addictions are quite prevalent among self-mutilating patients, this risk must be weighed against therapeutic benefit.

Antidepressants may be used in clinically depressed patients, although severe depression is an uncommon situation in this population.

Lithium has received considerable attention recently and seems to have some effectiveness in the treatment of outwardly and inwardly directed aggression. It has been tried in mentally retarded self-mutilators, but reports have been anecdotal; while the drug is worth considering, there is no definitive evidence that it is effective in establishing control of the behavior.

Finally, disinhibiting substances such as drugs and alcohol should be discouraged. Here, Antabuse may be helpful in maintaining sobriety.

While medications may be useful, the focus of treatment for the self-mutilating patient is psychotherapy—the patient and therapist working together to translate feelings into words and then discussing these feelings until the impulse to mutilate is overcome.

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The monthly lecture series is provided at no charge as a public service of Taylor Manor Hospital. ■

Psychiatric Commentary and References:

SELF-MUTILATION IN THE YOUNG

By Bruce T. Taylor, M.D.

Self-mutilation, including scratching, hitting, biting, pinching, head banging, and hair pulling, is not infrequent in the autistic and retarded and is often extremely difficult to control. Generally, it is viewed as a form of aggression and associated with a loss of impulse control. Cooper and Fowlie (1973) have suggested that the aggressive behavior observed in subnormal patients may be an affective (manic or depressive) equivalent. Goetzl, et. al. (1977) have noted that, in such patients "a clinical picture of cyclical overactivity, withdrawal, early morning awakening, self-mutilation and irritability may be signs of an affective diathesis. At times the suicidal behavior of children may be associated with mutilative consequences."

Pfeffer (1981) and Paulson, et. al. (1978) in studies of children ranging from four to 12 years, outlined a number of self-mutilation methods which have been employed. These include hanging, stabbing, cutting, scalding, burning, purposeful running into moving vehicles, and jumping from high buildings. Ackerly (1967), in a study of 31 latency-age suicidal children, hypothesized that a major ego regression to a psychotic stage and disruption in ego integrity occurs in children who make a serious suicidal attempt. He concluded that the degree of ego disruption is a way to differentiate between children who threaten and those who attempt suicide.

In addition to the various types of psychotherapeutic intervention employed in the management of self-mutilative behavior, treatment measures have included intensive individual care, recreation, constructive occupation, sedatives, tranquilizers, the use of lithium and, of considerable interest, those developed from classical or operant conditioning paradigms.

The rationale of behavioral intervention measures is based on the modification of specific target behaviors rather than attempting to cure presumed disease entities. Thus, although the syndromes or composite

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classes that characterize children who are diagnosed retarded or autistic may differ, as does the etiology of their disorders, both categories are similar in that they frequently display profound behavior deficits (e.g., self-help skills) and excesses (e.g., self-stimulating behavior). Intervention is therefore directed at each child's specific excesses and deficits, regardless of the diagnostic label attached to the child.

A case in point is a three-year-old visually handicapped boy who would poke his fingers into his eyes to the point of endangering his remaining vision, Kelly and Drabman (1977). Treatment employed a ten minute period. Each time the boy poked his eyes, the teacher raised and lowered the child's arm 12 times. This movement simulated an eye-poke but did not involve contact with the eye. Not only did this over correction procedure lower eye-poking but it also decreased difficulty in a 20 minute play period during which generalization was tested.

Good results in the treatment of self-mutilation behavior in mentally subnormal patients with lithium has also been reported by a number of writers. They include Dale (1980), Cooper and Fowlie (1973), Micev and Lynch (1974), Goetzl, et. al. (1977) and Sovner and Hurley (1981).

Cooper and Fowlie (1973) reported on a severely mentally retarded girl in her early twenties, having a long history of severe self-injury and mutilation, successfully treated with lithium carbonate. The impression was based on the severity of the initial symptoms and the fact that self-mutilation did not recur in a five year period of lithium treatment. Micev and Lynch (1974) carried out a trial on six male and four female severely mentally retarded patients, all of whom showed self-mutilation. While the effects of lithium on outwardly directed aggression were not consistent across the group of patients (5/9 showing such behavior as improved), there was a much more convincing effect against self-mutilation.

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Treatment Trends

A NEWSLETTER OF TAYLOR MANOR HOSPITAL

MULTIPLE PERSONALITY SYNDROME

By Gerald M. Lazar, M.D.

If an expert is someone who knows what they don't know, then I am a "maven" on multiple personality syndrome because there is so much that I don't know and so much that researchers are just discovering. This paper—an overview of the symptoms and treatment of multiple personality syndrome—will probably raise more questions than it will provide answers.

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Multiple personality syndrome is an easy diagnosis to miss. One can unwittingly treat people with this syndrome and never know it—as I now believe I did—because the symptoms are so varied and confusing. If you're not considering the syndrome you won't see it.

Historical Perspective

What may have been the first clinical documentation of multiple personality syndrome was by Paracelsus in 1646. Benjamin Rush described many patients with dissociation, and one specific case with multiple personality, in 1811. But the first case to draw attention in America was that of Mary Reynolds. She was born in 1785 in Birmingham, England. Several years later her family was unjustly attacked due to their liberal religious views, leading to their emigration to western Pennsylvania in 1798. Mary developed a seizure disorder and following a rather severe convulsion in 1811 she was found insensible; when she recovered she was blind and deaf. Within six weeks both her sight and hearing were restored, but a few months later she entered a deep sleep that lasted about 18 hours. Upon awakening Mary had no memory of her previous life (including her language).

Her family began the process of re-educating her and she learned rapidly. Five weeks later, upon awakening one morning, she was her original self and recalled nothing of the previous five weeks. These alternative personalities continued to appear over the next five years with amnesia occuring between these two states; one or the other personality dominated until her death at age 69.

Reports of multiple personalities and reaction to them can be broken into four periods. In the first period, prior to the nineteenth century, the phenomenon was new, and the reports were relatively straightforward and widely commented upon. The second period, in the 19th century, was characterized by a flurry of reports. The early 1900s to about 1970 was the

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third period: multiple personality syndrome fell into disrepute and the validity of the diagnosis was widely questioned. As a result, some people who formerly might have been diagnosed as multiple personalities were diagnosed as schizophrenics. (It's interesting that the decrease in the number of reported cases corresponds to an increase in the diagnosis and description of schizophrenia; this is probably a reflection of changes in diagnostic habits rather than in prevalence.)

What is probably the fourth period —although it's too early to tell—began in the early 1970s, with a dramatic increase in the number of reported cases.

Symptoms

As described in DSM III, there are three requirements for a diagnosis of multiple personality syndrome. "**1.** Within the individual there exists two or more distinct personalities, each of which is dominant at a particular time. **2.** The personality that is dominant at any particular time determines the individual's behavior. **3.** Each individual personality is complex and integrated with his own unique behavior patterns and social relationships."

Richard Kluft's Four Factor Theory offers an explanation of the etiology of multiple personality syndrome. "**1.** The individual has the biological capacity to dissociate. **2.** The individual encounters overwhelming life experiences during childhood that cause dissociation potential to become part of a defensive process. **3.** This dissociative defense is shaped toward personality formation by becoming linked with any of a number of normal and abnormal intrapsychic structures which form the nidus of another self structure or dissociated personality. **4.** The persistence and elaboration of such a pathologic outcome occurs when the traumatized, vulnerable individual is not provided adequate buffers against being further overwhelmed or given nurturing human experiences by significant others before the process becomes relatively fixed."

The average time that multiples are in treatment before diagnosis is made is seven years—and the average age upon diagnosis is 28. The literature suggests that the average time that multiples are in treatment after diagnosis is three to five years; but I think five or six years is more usual. Furthermore, the length of time in therapy appears directly proportional to the number of personalities.

The average time that multiples are in treatment before diagnosis is made is seven years—and the average age upon diagnosis is 28.

Multiples present innumerable and dramatically shifting medical, neurological and psychiatric symptoms.

The most common medical symptom is amnesia; it may be reported as blackouts, as time lost, or it may not be reported at all.

Amnesia, either partial or complete, is present in the vast majority of cases. Early in treatment the amnesia may be almost complete or complete; later on in treatment, or if they've been treated by someone else, there may be less amnesia. Even if they haven't been treated, a developmental process apparently occurs in which multiples begin to fill in some of their own memory gaps.

Amnestic episodes or losses in time have generally been present most of the patient's life and often are not experienced as unusual. The episodes may be relatively brief—limited to minutes or hours—or they may last weeks, months or years.

The second most common medical symptom is headaches, usually migraine-like. Headaches often occur at the time of switching and can become incapacitating.

There is anesthesia, convulsions, and paralysis, although these symptoms seem to be reported less than in the pre-twentieth century literature. Other symptoms involve the g.i. tract, visual symptoms, deafness, unexplained pain.

The most commonly reported psychiatric symptoms are depression and suicide attempts—which are often the symptoms that bring the patient into therapy. The host personality may be the presenter or make the suicide attempt or it may be an alternate who is persecuting another personality. What appears to be a suicide attempt may actually be a homicide attempt by one alternate against another.

Auditory hallucinations are reported in about 40% of the cases. They're of a different nature than those reported in schizophrenia: the voices are reported as internal, as a dialogue going on within one's head, rather than an external voice. Sleep disturbances—nightmares, difficulty in falling asleep or in waking up early —are also common.

Fatigue, anorexia (which seems to be on the increase), and psychosis are other psychiatric symptoms.

It may be difficult to get a history during the early stages of treatment. The patient may have trouble recalling past events or contradict the history previously given or may demonstrate difficulty remembering interaction with the clinician.

Between visits there may be dramatic changes in matters of personal style, in dress, in grooming; in personal habits such as smoking; in speech, including rate, pitch, pronunciation, and vocabulary. Handwriting also changes. A shifting, chaotic clinical picture can alert the clinician to the possibility of multiple personality syndrome.

The therapist should inquire if the patient is controlled by others if the

behavior is not directly remembered. Multiple personality syndrome patients, if asked, will frequently admit to finding themselves in places or situations without memory of how they got there or of finding themselves in clothes they do not remember putting on or buying.

Diagnosis

There is no blood test, cat scan, or psychological test for multiple personality syndrome: the diagnosis must be made in terms of one's clinical experience. But the following information about diagnoses—and frequent misdiagnoses—may provide some assistance.

The most common prior diagnosis is schizophrenia. Other misdiagnoses include manic-depression, temporal lobe epilepsy, and borderline personality disorder. A diagnosis of manic depression, for example, may be correct for only one alternate.

Organic brain syndrome may also be a diagnosis—and it may be correct. Misuse of drugs and alcohol is rather common and can lead to delirium. Temporal lobe epilepsy is a frequent diagnostic consideration and approximately one fifth of multiple personality cases exhibit some seizure-like phenomena.

Affective illness, particularly cyclothymic disorder must be considered; there is, however, a distinguishing characteristic: multiples tend to switch frequently, especially after they've been in treatment for a while. Cyclical affective illness is considerably less rapid. Moreover, the preservation of a unitary sense of personal identity distinguishes manic depressive illness from multiple personality syndrome.

Hysterical and atypical psychosis must be considered. Non-multiple forms of dissociative disorders and depersonalization syndromes may present similarly. These forms of dissociation, however, do not demonstrate the rapidly alternating shifts in personality of multiple personality syndrome. Personality disorders and transexualism may also confound the diagnosis.

Borderline personality is probably the diagnosis that causes the most confusion; in fact, there is debate as to whether multiple personality syndrome is actually a subvariant borderline personality. The consensus is that it is not, that it is a distinct diagnosis. But it is confusing because many characteristics of borderlines are also seen in multiples—from self-damaging unpredictability to identity disturbance and affective instability.

What appears to be a suicide attempt may actually be a homicide attempt by one alternate against another.

Diagnosis of multiple personality syndrome is confirmed by meeting the distinct and separate personalities. In about two thirds of the cases an alternate spontaneously reveals its existence to a surprised and unsuspecting clinician; in about 20 percent of the cases, the multiple personalities will emerge while the patient is under hypnosis. Rarely does the clinician suspect the diagnosis of multiple personality syndrome prior to meeting an alternate personality.

Characteristics of the Multiple Personality

Personality switches are usually manifested by a noticeable change in the voice, posture, affect, ideational content, and facial expression. The switches may be abrupt, literally measured in seconds or microseconds, or they may take minutes or extremely rarely, hours.

Generally, every personality has a name; it may be a derivative of the patient's name or identification with an important other person or may describe a function or attribute of the alternate personality.

The vast majority—85 percent—of the patients reported in the literature are female. This may reflect the higher rate of sexual abuse of girls vs. boys or it may be the case that males often have an alternate personality who is violent, ends up in jail, and is unreported as a multiple.

The average number of alternate personalities is about eight, although many cases have been reported of over 100 personalities. It would be impossible to meet all of those personalities in treatment; most people confine the majority of their work to four or fewer personalities.

There are usually several kinds of personalities in addition to the host personality. The most common alternate is the promiscuous personality; this is reported in about two-thirds of the cases. The second most common is the externally violent personality and the third is the internal persecutor who bears the function of destroying, maiming, or causing pain to another personality or personalities.

More than half of the multiples have one or more child-like personalities, who may sit on the floor, rock, and have a child-like vocabulary. Virtually every personality will have a different age, which may reflect when each personality was created. The depressed personality, who may or may not be the same as the suicidal personality, is another common alternate.

There is usually an arbitrator, otherwise known as the "ISH"—Internal Self Helper. This personality can be very helpful in letting the clinician know what's going on. A substance abuser may be a distinct alternate or may be the suicidal or depressed personality.

There are significant and sometimes startling differences between and among alternates. For example, alternates seem to have differing reactions to drugs—from antibiotics to antidepressants. The differences in tastes and values mean the multiple has to deal with constant dilemmas and conflicts.

Rarely does the clinician suspect the diagnosis of multiple personality disorder prior to meeting an alternate personality.

All multiples have some kind of system for the alternates to relate to one another. The system can take one of several forms: e. g., concentric circles where everybody in the circle knows one another, but they don't know anyone in the other concentric circles so there may be total unawareness of a whole group of alternates. There may be a "bridge personality" —one of the alternates in a circle who knows one or more alternate personalities in one or more circles.

Another kind of system is the family tree: a mother, a father, and children, all of whom know each other and talk about each other as mother, father, or child. And that family may or may not know about another family. They may all share a common last name. These are but two of endless possibilities.

The systems are usually very creative and are crucially important to understanding multiples completely.

Childhood Histories of Multiples

The average age of the first split is about seven years old. The children undergo extreme emotional, physical, and sexual abuse. They are beat up, cut, burned, tied up and locked up and left for hours or days; they endure attempted drownings, and are forced to watch the physical or sexual abuse of siblings or others.

If there is no one to protect them, these children endure torture more or less continuously for years. But they are extremely creative. They seem to combine creativity with the biological ability to dissociate for self-protection during periods of extreme abuse. Abusive incidents are screened off from direct recall by amnesia, and the affects generated by the trauma are sequestered in alternate personalities. The alternates may serve in some way as a support system even though they may be internal persecutors.

The signs and symptoms of multiple personality syndrome in children are: **1.** do not remember abuse when there are reports from others; **2.** exhibit marked changes in personality; **3.** are unusually forgetful or seem confused about very basic things; **4.** show marked variations from day-to-day or hour-to-hour in food preference, skill, knowledge, athletic abilities, handwriting; **5.** demonstrate rapid regressions in behavior or marked variations in age-appropriate behavior; **6.** appear to lie or deny their behavior when the evidence is obvious and believable; **7.** have rapidly fluctuating physical complaints and hysterical symptoms; **8.** frequently sleep walk; **9.** refer to themselves in the third person or insist on being called by a different name at times; **10.** self-mutilate or engage in dangerous or self-destructive behavior as well as suicidal behavior; **11.** are abnormally sexually precocious and initiate sexual behavior with other children or adults; **12.** report auditory hallucinations.

The use of self-hypnosis is learned by multiples in childhood. Some researchers even define multiple personality as a type of self-hypnosis.

Treatment

The most important thing to remember in treating multiples is that it's very easy to become an ally of one alternate and agree that another alternate is bad, or should be eliminated. The eventual result can be a crisis for the clinician when the time comes to work with the "bad" alternates.

It is extremely important to meet all the personalities or as many as possible, to be empathetic, concerned, respectful, to be responsive, and to be flexible about the time available to these patients. Being in touch with what's going on in oneself is extremely important. The multiple will challenge you and ask you directly what you feel and think; if you don't answer, you probably won't meet some of the other personalities.

Just keeping track of the transferences and/or counter transferences makes these individuals extremely challenging to work with. And because they have a real potential for violence or suicide they are difficult patients. But work with multiples can also be extremely rewarding.

One third to a half of the patients get significantly better with the combination of hypnotherapy and psychotherapy. Those who stay in treatment have a much higher recovery rate.

In general, medications are not helpful because of the side effects that

affect some of the alternates. In addition, multiple personality syndrome patients as a group are more prone to accidental or intentional overdose, and physical and psychological addictions.

Early in treatment, group therapy is probably not useful—in fact, it can be counterproductive. However, as personalities are being integrated it can be helpful.

Videotapes—especially at the time of diagnosis—can be an important treatment tool. Videotapes can help multiples accept the diagnosis. But if it happens too early in the therapy, it can be very frightening to the patient and resistance is then likely.

The next step is to meet with as many of the alternates as possible and get a history of each one: When they were created, what circumstances led to their creation, their purpose, what they've gone through, and who they know and don't know in the system. One of the therapist's most important roles is to act like a bridge alternate, telling various personalities what's going on, and filling in memory gaps.

One often has to make contracts with a multiple in order to control dangerous behavior. The therapist must be ready to carry out the consequences of whatever that contract is.

Beginning the process of internal dialogue is extremely important. Early in treatment the therapist relates what one personality is doing to another personality who has no memory of that personality being at a session; eventually, an internal dialogue develops between two personalities and then three and then it's almost as though they are in group therapy. At this point it's important to help the multiples make their own decisions by sharing information.

By this time past traumas have been touched on—which is essential for integration. Without abreaction, catharsis, and working through, integration will be impossible. In the process, there is considerable resistance, sadness, anxiety, and the potential for violence. Some alternates will have no memory of the trauma, others will recall a great deal. Traumatic memories are often first experienced as flashbacks or dreams; the patient is often unclear as to whether or not the events actually happened or if he or she made them up.

Just keeping track of the transferences and/or counter transferences makes these individuals extremely challenging to work with.

It can be helpful to go through the abreactions and the same historical material two, three or even more times in order to make sure the various personalities know the important events.

The last phase of therapy is resolution and integration. There will be a distribution of affects and memories across a large number of personalities. There will be a loss of distinction between the alternate personalities and the development of co-consciousness among most of the personalities. Spontaneous integration may occur involving one or two personalities or the patient may report a desire for fusion of personalities. Frequently pairs of personalities with common traumatic origins will fuse together; these are often personalities that are flip sides of each other—the "good" and "bad" personalities.

Final integration is often done with hypnosis. Multiples build a resistance to integration. Each personality feels threatened, afraid to be eliminated or lost. As therapy evolves they come to the realization that skills and creativity won't be lost, but that with integration they'll be a healthier, functioning person. Typically, they then want complete integration.

As mentioned, working with multiple personality patients is both challenging and stimulating. Because the issues are so confusing, anyone who believes they are treating a multiple is urged to find other therapists treating multiple personality patients and form a support group.

The Fourth International Conference on Multiple Personality/Dissociative States will be held November 6-8, 1987, in Chicago; there will be a special emphasis on Post-traumatic Stress Disorder and Dissociation. This is one of the best-organized and most informative conferences I've ever attended and I recommend it highly. For additional information about the conference and/or membership in the International Society for the Study of Multiple Personality and Dissociation write or call Bennett Braun, M.D., 230 N. Michigan Avenue, Suite 3201, Chicago, IL 60601 (312) 750-0552.

An annotated bibliography on Multiple Personality Syndrome is available from the Taylor Manor Hospital Community Relations Office—
301/465-3322, ext. 212
301/621-4965, ext. 212; (Washington)

Dr. Lazar is a psychiatrist at Wasatch Canyons Hospital in Salt Lake City. From 1972-1986, he was an instructor in the Johns Hopkins Hospital Department of Psychiatry, and from 1980 to 1986 an assistant professor in the University of Maryland Department of Psychiatry. ■

Taylor Manor Hospital

Letter to the Editor

I enjoyed Dr. David L. Shapiro's review of current issues in mental health law in the November issue of your newsletter, Treatment Trends but I want to share with you my concern that reliance on the author's statement on page four, column 3, that in Maryland, *Shaw v. Glickman,* 45 Md. App. 718, 415 A.2d 625 (1980), established that there is no duty to warn could generate a false sense of security and unsound reliance exposing psychotherapists to liability. I have heard this same interpretation of *Shaw* propounded at a risk management conference before psychiatrists and believe that it is very dangerous. *Shaw* raises the issue of the duty of a psychotherapist when he believes that a patient under his care poses a serious threat of harm to another. The therapist has a duty to maintain the confidentiality of the patient-psychotherapist relationship, yet there may be a *Tarasoff* duty, that is, a duty to prevent serious harm to intended victims. *Tarasoff v. Regents of the University of California,* 17 Cal. 3d 425, 131 Cal. Rptr. 14, 551 P.2d334 (1976). I am concerned because *Shaw* is not dispositive of the law in Maryland, and I believe that *Tarasoff* presents a very real threat to psychotherapists in this situation in Maryland....

Linn Turner Greenberg, M.D., J.D.

Copies of Dr. Greenberg's complete letter are available from the Taylor Manor Hospital Community Relations Office—301/465-3322, ext. 212 301/621-4965, ext. 212; (Washington) ■

Psychiatric Commentary and References:

MULTIPLE PERSONALITY SYNDROME

By Bruce T. Taylor, M.D. and Albert A. Kurland, M.D.

The DSM III lists among the dissociative disorders psychogenic amnesia, psychogenic fugue, multiple personality and depersonalization disorder. The essential feature is a sudden, temporary alteration in the normally integrative functions of consciousness, identity or motor behavior. If it occurs in identity, either the individual's customary identity is temporarily forgotten and a new identity is assumed, or the customary feeling of one's own reality is lost and replaced by a feeling of unreality. If the alteration occurs in motor behavior, there is also a concurrent disturbance in consciousness or identity—as in wandering that occurs during a psychogenic fugue.

Each of these diagnostic identities has evolved into a formalized concept in relatively recent times with that of the Multiple Personality reflecting an interesting sequential history. Although the existence of multiple personality as a clinical phenomenon has been demonstrated beyond any reasonable doubt, contemporary reports have raised serious doubts as to whether multiple personality can continue to be regarded as a rare condition. With the refinement of the diagnosis and treatment of schizophrenia and affective disorders, other categories of diagnosis have come to the fore.

Historically, Volgyesi (1963) cites Paracelsus in 1646 as recording a case of multiple personality: a woman reported that another personality pilfered her money and she remembered nothing. Bliss (1986) notes that Rush described several possible examples in 1812, and in 1817, Mitchell reported the case of Mary Reynolds under the title: "A Double Consciousness or a Duality of Person in the Same Individual." Between 1889 and 1906 other cases were reported. In 1944 Taylor and Martin reviewed these examples and added others. Greaves (1980) identified 50 cases between 1970 and 1980, to which Boor (1982) added 29 more. However, it would appear that cases are being detected in increasing numbers, Kluft (1982, 1984).

Currently, the criteria for the diagnosis of multiple personality as outlined in DSM III are: The existence within the individual of two or

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more distinct personalities, each of which is dominant at a particular time. The personality that is dominant at any particular time determines the individual's behavior. Each individual personality is complex and integrated with unique behavior patterns, and social relationships, Spitzer (1980). In a recent monograph on the syndrome of multiple personality, Bliss (1986) comes to the conclusion that the fundamental trait of the multiple personality is that of spontaneous self-hypnosis, and as such demonstrates the capacity to produce numerous symptoms, personalities and irrational behaviors. Bliss bases his impression on evidence suggesting that most are excellent hypnotic subjects and capable of posthypnotic amnesia.

Though considerable controversy persists relative to the syndrome, there is doubt that personalities can be readily interviewed when the patient is under hypnosis. The question remains as to whether these personalities have been there all along, or are they a reaction induced by the psychiatrist. Ultimately, the answer may depend to a great extent on the patient's honesty. Bliss (1986), in discussing his criteria, is of the opinion that "unless it can be ascertained that they were created at an earlier date to cope with forgotten traumatic experiences or serve functions unacceptable to the patient, I have not considered them to be personalities ... If the individual hypnotically has concealed repugnant experiences, intolerable emotions, or unacceptable functions, and they are embodied in personalities, then the disorder is viewed as one of multiple personality." Bliss (1986) also states "some patients with many symptoms rapidly recover after a few sessions during which their amnestic traumas are revealed and made conscious. In these cases, if all symptoms disappear and the recovery persists, there is considerable assurance that the amnesias were the culprits. But in lengthier cases, those in which therapy may extend over many months or years, it becomes difficult to prove with scientific rigor that the return to consciousness of unconscious traumas was the essence of the therapeutic process—although both patients and therapist may have this conviction."

A recent study by Coons and Milstein (1986) of 20 patients who met DSM III criteria for multiple personality disorder, provided some unexpected findings. Although their patients had experienced a greater degree of physical abuse, sexual abuse and rape in comparison to a control group, they exhibited only a slightly greater incidence of psychosexual disturbances. This raised the question as to why more individuals with a multiple personality disorder do not suffer from psychosexual disturbances due to their sexually traumatic backgrounds. In response to their observation, Coons and Milstein (1986) were of the opinion that the individual afflicted with the disorder utilizes the defense mechanisms of repression, denial and disassociation to deal with traumatic experiences. Various traumas and their associated effects are compartmentalized in various personalities and there is relatively little leakage of affect or knowledge between different personalities. It was also their impression that many multiple personalities create a personality, isolated from various previous and contemporary physical and sexual traumata, to deal specifically with sexuality. Moreover, the multiple personality syndrome, while it may be an adaptation to repeated trauma, is maladaptive in other respects.

Outcome data in such patients remains sparce. Coons and Milstein (1986) point out that there is only one published study concerning outcome of a group of patients with multiple personality disorder—namely that of Kluft (1984), and only a few reports of outcome in single patients. Greaves (1980) on the basis of his extensive clinical experience is of the impression that the prognosis for complete or near complete remission of multiple personality through the joint efforts of patient and supportive therapist, making use of various techniques of integrative psychotherapy and/or hypnotherapy, must now be regarded as favorable.

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Taylor Manor Hospital

Continuing Education Lecture Series

Location: Taylor Manor Hospital
Time: 3:00 P.M.

Computers and Mental Health: A Look at the Future

A look at the dramatic changes that will occur in medicine produced by advances in biotechnology, changes in the form of health care practice, and the extensive influence of computers in the mental health field.

January 14, 1987

Raymond D. Fowler, Ph.D.
Professor Emeritus,
University of Alabama
Senior Consultant,
National Computers System

The Family Physician's Approach to Headaches

The pragmatic evaluation and treatment of the most common forms of headaches seen in office practice. There will be emphasis on the emotional aspect of headaches, and a section describing the common headache, and treatment of headaches in children.

February 18, 1987

Paul A. Valle, Jr., M.D.
Consultant in Family Practice
Franklin Square Hospital Center

The Religious Dimension in Mental Health Treatment

An examination of some of the ways in which mental health professionals can more effectively deal with the religious dimension of their patients' lives, and whether that religious dimension has become entangled in pathological patterns of adjustment or has been woven into the strong fabric of psychological health.

March 18, 1987

Robert J. McAllister, M.D.
Director, The Isaac Taylor Institute of Psychiatry and Religion
Taylor Manor Hospital

For further information please contact the Community Relations Office—(301) 465-3322, ext. 212; Washington, D.C. (301) 621-4965, ext. 212.
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Treatment Trends

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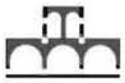

Treatment Trends

A NEWSLETTER OF TAYLOR MANOR HOSPITAL

LITHIUM MANAGEMENT OF THE YOUNG BIPOLAR PATIENT: A LONGITUDINAL PERSPECTIVE

By Raymond DePaulo, Jr., M.D.

Young people typically present with a variety of psychopathologies, so it is important to review the diagnostic issues of bipolar disease before discussing the treatment issues.

The History

Getting a clear family history is enormously helpful in making a diagnosis of bipolar disease. In fact, it is often crucial. Such a history may show not only mania and depression, but also suicidal behaviors, alcoholism, bulimia or antisocial behaviors that may represent responses to depressive or manic states in some family members.

The patient's history is typically one of an episodic disorder with a return to the usual level of functioning. There may also be, in the medical history, associated endocrine and neurological disorders. A history of drug exposure can be very important in adolescents, for example, prescription drugs, such as systemic steroids for allergies, or arthritic disorders. Street drugs like PCP have been associated with affective episodes. We have sent a number of clear manic episodes in patients immediately following the ingestion of a substantial amount of PCP.

Another point to remember: Very early onset of depression is more likely to be associated with a bipolar outcome than is a later onset.

Unfortunately, many cases of manic-depressive illness in young people are missed when clinicians conclude that the patient is not fully recovered from prior episodes of illness, despite the fact that it's difficult to know what full recovery is in a developing person. Fully 20% of affective episodes don't resolve within two years. In fact, in an adolescent, depression may run two, three or four years.

The Mental Status:

From a cross-sectional perspective, the central features of the affective syndrome, in either the manic or depressive state, are changes in mood, self attitude and vital sense.

By self attitude, I mean the patient's attitude toward himself, which, in the depressed state may be hopelessness and worthlessness; and in the manic state, inflated self-confidence and self-importance.

(Continued on page 2)

This issue of *Treatment Trends* contains another presentation made as part of Taylor Manor Hospital's Continuing Education Lecture Series. Taylor Manor Hospital offers these programs without charge to health care professionals. Regular announcements of upcoming lectures are contained in each *Treatment Trends* issue.

See page eight for the current calendar. ■

(Continued from page 1)

From a cross-sectional perspective, the central features of the affective syndrome, in either the manic or depressive state, are changes in mood, self attitude and vital sense.

Vital sense is the patient's subjective assessment of his mental and physical functioning. Depressed patients will feel that they can't concentrate or that their thinking is slowed, muddled or confused. They often complain of memory problems that aren't found on objective examination. They also tend to feel physically fatigued and tired all the time. This latter problem is particularly noted in the early morning hours and may improve once they "get into the day."

Manic patients, on the other hand, will report their thinking to be rapid and "clear as a bell." They describe themselves as having no problems in making decisions. They usually feel a greater sense of energy, drive and general well-being.

Other features of affective syndromes often include abnormal experiences and beliefs. Hallucinations and delusions are quite common in these syndromes. Their content, usually can be related to mood, although occasionally, some seem "mood-congruent." This situation leads some clinicians to conclude that paranoid delusions "couldn't be" manic or depressive. By exploring the reasoning and the premises of the delusion with the patient, you may find that he believes that people are trying to kill him because he has the "secret of eternal life" or the "secret of ultimate power" and, therefore, is the object of envy. Bipolar patients with these kinds of delusions are too often misdiagnosed as schizophrenic.

When a patient has the central features of an affective syndrome and many delusions, most of them are related to mood, diagnosed by the mountains and not by the molehills.

Delirious mania is occasionally seen in adolescents. These severely manic patients are so driven and speeded up in their thoughts that even they feel that they can't keep up with them. Because of this severe speed-up, they may be unable to maintain orientation as to location, date and time. It is also true, particularly in adolescents and young adults, that after the patient becomes manic, then he/she may ingest drugs and alcohol and present an intoxicated delirium with manic features present as well.

Treatment Responses to Lithium

Older and more recent studies have shown that only about 50-60% of bipolar patients who are put on lithium go two years without at least one relapse. This is a crucial point. Most of the patients who have relapses were probably getting some therapeutic benefits from lithium. However, in half of the bipolar patients who we appropriately treat with lithium, we do not eradicate the disorder (even if they are taking their lithium as prescribed).

We hope to attenuate the disease, to make the time between episodes longer, the duration of episodes shorter and the severity less. This is the usual treatment response. It is also very important for us to realize that lithium works very well for about half of our patients, but that it just doesn't work as well for the other half.

Some evidence suggests that the best responses to lithium occur at relatively low serum lithium levels. It is possible that patients with higher blood levels are often the ones who respond partially but not completely to lithium and who experience more side effects.

A few years ago concerns were raised about giving lithium to old people. A study by Jon Hommelhoch (University of Pittsburgh) assessed which factors contributed to poor therapeutic response or to an increased likelihood of lithium intoxication. He found that age by itself was a very small factor. The significant factors were neurological disorders and to some extent drug abuse. These issues, particularly drug abuse, are very important in young people.

Another factor to be assessed is the history of lithium response in a family with affective disorders. There is some evidence to suggest that in a family with a history of poor response to lithium, a new onset of affective disorder in a family member predicts that the patient will also have a difficult time with lithium treatment. In one extended family of 12 people that I have treated with lithium, there is yet to be a good response to the medication.

Older and more recent studies have shown that only about 50-60% of bipolar patients who are put on lithium go two years without at least one relapse.

The Toxicities of Lithium

There are so many potential side effects to lithium that one needs a schema to organize them. I divide the side-effects into three groups: early side effects, maintenance effects and toxicity.

We hope to attenuate the disease, to make the time between episodes longer, the duration of episodes shorter and the severity less.

Early side effects are those the patient gets in the first two weeks. They are primarily gastrointestinal—nausea, vomiting and diarrhea—although there can also be lethargy and complaints of "just not feeling right" or being unable to collect one's thoughts. Such effects are associated with rapidly rising lithium levels, regardless of the absolute level at any particular time, and patients typically get better after two weeks of treatment. While these side effects may be unpleasant—no one likes to throw up—it's important not to stop the medication because of them. One way to help the patient is to get the lithium level to rise less rapidly by reducing the initial dosage and advancing the dosage more slowly. For people who are particularly sensitive to lithium, you may need to give them an antiemetic an hour before their lithium dose for the first couple of weeks. Since these are usually manic patients and since chlorpromazine is a helpful drug in treating both mania and nausea, I usually give these patients a small dose of chlorpromazine concentrate an hour before their lithium dose. This usually takes care of the problem.

There are so many "maintenance" side effects that it takes a medical review of systems to cover them all. In vulnerable individuals these side effects occur at blood levels that are considered therapeutic and non-toxic and get worse as the level goes up. Being in the "therapeutic range" may be little protection from these effects.

It is estimated that 40 to 80% of patients get hand tremor. Neuroleptics, anticholinergics and tricyclics make the tremor worse.

Hypothyroidism is another important but infrequent side effect. Since it may influence the course of the patient's affective disorder, it is all the more important to recognize and treat it.

A potential long term risk is the renal side effect of lithium. The most powerful aspect of lithium treatment in terms of producing renal consequences is the duration of time the drug is taken. That makes careful management especially relevant to young people who are going to start on lithium and whose prospects are that they will be on it for 40 or 50 years.

There seems to be a statistically significant correlation between duration of lithium treatment and 24 hour urine volume. It appears that it is based on the small fraction of patients who are predisposed to a progressively severe polyuria. Fortunately, the data also suggests that lowering the lithium levels may alleviate the problem. Thus it appears that when we anticipate a lifetime of treatment, that we should use the lowest possible blood levels consistent with good care to control the illness.

Toxic side effects which are related to an absolute level usually result when the patient level is greater than 1.5 miliequivalent per liter, although this isn't an absolute since everybody seems to have their own threshold. The co-administration of neuroleptics and other medications like Dilantin may alter the blood level at which people get delirious and intoxicated.

There are really only two ways to get lithium intoxication—ingest too much or excrete too little—and the best treatment for lithium toxicity is to prevent it.

Lithium intoxication in young people often results from changing their dosage just before they leave the hospital. By not waiting for the five to six days it takes for levels to stabilize, the desirable steady state lithium level may be exceeded. In addition, occasional parents who are administering the medication to their children and who are anxious for them to continue it may insist that lithium be taken even after early signs of intoxication appear in their child, leading to more severe intoxication.

On the excretion side, anything that lowers glomerular filtration rate will increase lithium levels. In addition, anything that enhances proximal tubular reabsorption will increase lithium levels because the proximal tubule is the site for most lithium and sodium reabsorption. Lithium is reabsorbed (with sodium) in the proximal tubule and in the early part of the descending part of the loop of Henle.

It is also very important for us to realize that lithium works very well for about half of our patients, but that it just doesn't work as well for the other half.

Further sodium may be reabsorbed in the distal tubule but no lithium is reabsorbed distally. Therefore, anything that will decrease distal tubule reabsorption of sodium will influence the proximal tubule to reabsorb more sodium and, with it, more lithium. That's why the patient can't afford to become hyponatremic.

Low salt diets are to be avoided. When your patient wants to go on a

diet to lose weight or to combat hypertension, you need to explain the possible problems and closely monitor both their diet and their lithium blood levels.

The use of diuretics, particularly thiazides which act in the distal tubule, is also hazardous unless you have lowered the patient's lithium dosage and are monitoring their levels closely.

Some evidence suggests that the best responses to lithium occur at relatively low serum lithium levels.

Non-steroidal anti-inflammatories, some of which are now available over-the-counter, will have an effect similar to thiazide diuretics. Patients will reabsorb more lithium and problems will occur when their lithium levels go up.

Anything that leads to hypovolemia will increase the concentration of lithium and may lead to a spiraling lithium level. Lithium itself induces nephrogenic diabetes insipidus, leading to polymia and thereby, water loss. If patients don't drink enough fluids, they become dehydrated. This leads to hypovolemia and, eventually, to lithium intoxication. There may not be a major problem if someone has a mild diabetes insipidus since the syndrome itself drives the thirst mechanism and people drink the water they need. The problems come when patients have a depression, delirium, lithium intoxication or other problems that impede their access to water or their motivation to get it.

Special Problems of Youthful Patients

Once young bipolar patients get beyond the acute phase, are on the proper drugs and are leaving the hospital, they must be convinced that they need to continue to take their lithium. By and large these patients have a difficult time understanding and accepting the notion that there is a disease affecting their moods. If, for example, they were manic, it is very hard for them to see how something that made them feel that good could be a disease. Obviously, this approach leads to a lot of problems with compliance. Sometimes it takes repeated cycles of relapse-medication-noncompliance-relapse before they come to accept the idea that they do have a disease and need to continue their lithium in order to control it.

Another problem in treating youthful bipolar patients is that the prognosis is more unpredictable. When you have 40-year-old patients who have bipolar illness, they usually have had previous episodes and you can use their past histories as a way to gauge what is likely to be their prognosis for the short and intermediate future.

But if this is the first episode, you don't know if this youngster is going to be the one in twenty manic patients who don't have a relapse. You know it's very unlikely that he is, but you don't know if or when there will be a relapse. When youngsters say they have only had one episode and want to go off their lithium, I think that it's important to review the charts, talk to the parents, spouses, boy or girl friends or those who know them well. That way we often get information that this was not the only episode them have had and they really have been symptom free on lithium. Such "outside" evidence may help persuade young patients that the medication is important.

There is some evidence to suggest that an earlier onset of the disorder may be associated with a more severe prognosis. It's still controversial but in any genetic disorders, as a general rule, the earlier the onset the more severe the disorder. There is no doubt that drug abuse will, even in the presence of lithium, have a negative influence on the therapeutic effect.

Just being youthful can create potential problems. Young people are generally in transition with their parents and find it hard to return to them, especially if they have left the home, for emotional support or guidance. They usually have no spouse to bring them for treatment and to encourage them while they are getting treatment. They also may have had no long term job success so there aren't employers and colleagues encouraging them: "we need you to get well and get back to the job."

There is some evidence to suggest that in a family with a history of poor response to lithium, a new onset of affective disorder in a family member predicts that the patient will also have a difficult time with lithium treatment.

Conclusion

Obviously there are many features of manic depressive illness in young people that are no different than anyone else's. Diagnosis is crucial. Lithium treatment should be carefully monitored and levels maintained at the lowest possible level consistent with good control of the illness. But because of the stage of life of younger people there are multiple interactions, both with the therapeutic effects of lithium—particularly in regard to drug abuse—and with the toxic effects of lithium—in regard to the duration and its effect on the renal function. And, lastly, the immediate management of younger people may be made

more difficult because of their lack of stable social support, and their reluctance to depend on their parents.

This is a group that requires a great deal of attention and careful management.

J. Raymond DePaulo, M.D., Associate Professor of Psychiatry at the Johns Hopkins School of Medicine in Baltimore, Maryland, Dr. DePaulo is also Director of Education in the Department of Psychiatry and Director of the Affective Disorders Clinic of the Johns Hopkins Hospital. His research has focused on the clinical effects of lithium therapy, and on mood stability in manic-depressive patients. Dr. DePaulo has published a variety of scientific articles and book chapters, including several studies on psychiatric aspects of neurological disorders. ■

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LITHIUM MANAGEMENT OF THE YOUNG BIPOLAR PATIENT: A LONGITUDINAL PERSPECTIVE

By Bruce T. Taylor, M.D. and Albert A. Kurland, M.D.

Van Krevellen and Van Voorst (1959) are generally credited with the first reported use of lithium in an adolescent. This involved a 14-year-old retarded boy hospitalized for alternating depressive and hypomanic states. He had failed to respond to chlorpromazine but showed an excellent response to lithium carbonate. Since that time classical bipolar manic-depressive symptomatology in early, middle and late adolescence has been increasingly treated with lithium. Yongerman and Canino (1978) in a survey of the literature of lithium carbonate use in children and adolescents found 190 cases. Utilizing DSM-II criteria they divided the cases into: 1.) major effective disorders (manic depressive illness and atypical major affective disorders); 2.) behavior disorders of childhood

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Taylor Manor Hospital

Letters to the Editor

We appreciated Dr. Gerald Lazar's article, and Drs. Taylor and Kurland's commentary on Multiple Personality Disorder (MPD). It is heartening to see more information available to clinicians about MPD, as we discover that the disorder is not as uncommon as once believed.

Through our work with Incest Survivors, Post-Traumatic Stress Disorders, and Dissociative Disorders, we have both worked for some years with a surprisingly large number of individuals who suffer from MPD.

We would like to respond to Drs. Taylor and Kurland's statement that, "there is doubt that personalities can be readily interviewed when the patient is under hypnosis. The question remains as to whether these personalities have been there all along, or are they a reaction induced by the psychiatrist."

Both Richard P. Kluft, M.D., and Bennet G. Braun, M.D., have researched and written extensively about the use of hypnosis in the treatment of MPD. They have concluded that hypnotic interventions, when used as an adjunct to supportive psychodynamic psychotherapy, can only enhance treatment rather than creating further splits. Any splits that one might see in the course of treatment would most likely be of a temporary defensive nature (a "special purpose fragment" in the nomenclature of MPD research), as opposed to a fully developed alternate personality. This can be quickly resolved through the knowledge and skills of a psychotherapist who has developed a positive and trusting relationship with their patient.

A well-trained and skilled psychotherapist, with a knowledge of MPD, should be able to use hypnotic interventions as an important and useful adjunct to the therapeutic process with MPD patients, without the concern that it would further complicate the treatment.

Terry Dalsemer, MMH, LCSW
Joan Baggett, LCSW

The comments of Ms. Dalsemer and Ms. Baggett are well taken. Our previous comments were in no way meant to imply that hypnosis in skilled clinical hands is not a useful tool in the treatment of multiple personality disorder. We were commenting on the fact that others have posed these questions and attempted to answer the proverbial chicken and egg question. Our presenting this review of the literature is for overview purposes and is not meant to depreciate the value of hypnosis.

Bruce T. Taylor, M.D.
Associate Medical Director

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and adolescence (unsocialized, aggressive reaction of adolescence and hyperkinetic reaction of childhood); and 3.) schizophrenia, childhood type. They found among these 20 reported cases of rather typical manic-depressive illness—two in childhood and 18 in adolescence—successfully treated with lithium carbonate. Moreover, despite occasional concomitant organic features, including mental retardation, seizure discharges, and EEG abnormalities, the classic symptomatology of alternating mania and depression was present and successfully treated. In many of these cases of the drug responders, the clear manic-depressive pattern often merged from an indistinct prodromal history of other affective upsets. Significantly, a family history of bipolar affective illness was observed in many of these cases.

Lena (1980) in a less detailed overview discussed the use of lithium in the following groups: 1.) manic-depressive illness (the classic form and "juvenile" or "masked manic-depressive illness); 2.) hyperactivity; and 3.) aggressive behavior. Jefferson (1982) in a subsequent review added an additional 20 reports.

Nevertheless, despite an increasing number of reports, all of the reviewers continue to emphasize the dearth of controlled investigations as to the usefulness of lithium in the younger age group and are of the impression that this issue is far from established even though most of the reports have indicated that there is clinical evidence as to its efficacy. The use of lithium in the young patient, despite the progress made, confronts the clinician with diagnostic challenges of considerable magnitude. Affective symptoms may be mixed or masked and it is difficult to elicit reports of sustained mood swings.

Another point of contention is the diagnostic and therapeutic specificity of lithium. Schou (1971) has drawn attention to the fact that not all who respond to lithium, are responding because of an affective disorder. A non-specific anti-aggressive effect of lithium has been demonstrated in open, single blind, and double blind studies that is not related to an underlying affective disorder, Marini and Sheard (1977). It is also well to note that among classic manic depressives although 70-80% are responsive to lithium there is as yet no clear understanding to account for the failure of the 20-30% that do not respond.

Where maintenance lithium therapy is started in the young patient with the potential for more lithium exposure years over the lifetime of the individual, there is potentially a greater risk for adverse effects. Among these are alterations in renal function, biological and psychological growth, and endocrine effects. The clinical implications of most endocrine effects of lithium have not been established for either adults or children. Judd et al (1977) have demonstrated in normal volunteers, lithium can cause a slight but definite impairment of mood, learning, concentration, comprehension and memory; effects which raise as yet unresolved issues. But as Jefferson (1982) has stated "a proper balance must be struck between the potential adverse drug effects and the devastating effects of untreated illness."

Finally, it should be noted that as yet lithium is approved by the FDA only for the treatment of manic episodes and for maintenance therapy in manic-depressive patients with a history of mania. The package insert cautions regarding usage in children. "Since information regarding the safety and effectiveness of lithium carbonate in children under 12 years of age is not available, its use in such patients is not recommended at this time, an admonition that places the clinician at risk if he ventures beyond this point without extreme caution. ■

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A NEWSLETTER OF TAYLOR MANOR HOSPITAL

THE DANGEROUS PATIENT AND PSYCHIATRIC LIABILITY

By Linn T. Greenberg, M.D., J.D.

In *Tarasoff v. Regents of the University of California,* a landmark case for the mental health profession, the California Supreme Court held that when a psychotherapist determines that a patient presents a threat of serious harm to an identifiable person, the therapist has a duty to take steps to prevent the harm. This may include warning the intended victim even though this warning violates the confidentiality privilege which exists between a psychotherapist and his patient. While case law had already recognized the duty of a physician to take precautions for the safety of persons threatened by his patient, this was the first time a court held that the duty at times would require a breach of the confidentiality privilege.

At common law there is no legal duty of an individual to act to prevent harm to another unless some special relationship such as parent-child, employer-employee, or physician-patient exists between them. Case law antedating *Tarasoff* had established the duty of a physician to take precautions for the safety of persons threatened by infectious diseases carried by his patient or threatened by his patient's driving a car when the patient's condition or medication renders driving dangerous. Case law also had recognized the specific duty of a therapist to control his patient or to decrease the risk of the threat when his patient is determined to be dangerous to himself or to others.

The *Tarasoff* decision was strongly denounced in psychiatric circles because of its holding that a psychotherapist may be required to breach the confidentiality privilege upon which his patients rely. Many authorities believe that success in psychotherapy depends on the confidential nature of communications. Psychotherapists may be deterred from treating dangerous patients if they may be liable to a patient for a breach of confidence and to a victim for a failure to warn. There is great potential for ultimate detriment to public safety.

However, not all authorities agree that requiring such a warning would be detrimental to psychotherapy. Fleming and Maximov argue that limits to the confidentiality privilege have not been demonstrated to be harmful to psychotherapy. In fact,

(Continued on page 2)

This issue of *Treatment Trends* contains another presentation made as part of Taylor Manor Hospital's Continuing Education Lecture Series. Taylor Manor Hospital offers these programs without charge to health care professionals. Regular announcements of upcoming lectures are contained in each *Treatment Trends* issue.

See page eight for the current calendar. ■

such limits can help screen out exaggerated threats of violence. The knowledge that threats could lead to warnings might induce patients to censor threats which do not embody any real intent of harm. Dr. Richard Carlson, speaking at the American Academy of Psychiatry and Law, reported that studies have shown that the *Tarasoff* duty has actually helped in these situations. It has enhanced the trust of patients, enabled them to explore ambivalent feelings of violence, and reduced such violence and its attendant consequences to both patient and victim.

While it is reasonable for a patient to expect confidentiality of his communications to his psychotherapist, it is also reasonable for him to expect that such confidentiality is limited. It is not reasonable for a patient to expect a therapist to allow him to inflict serious harm on another person. In *Tarasoff* the court looked to the exceptions to the evidentiary privilege as evidence of California's legislative policy in balancing the interest in confidentiality against the interest in public safety. Among the enumerated circumstances when a California physician can be required to divulge confidential communications in administrative, legislative, and judicial proceedings is the jeopardy of public safety.

Psychotherapists need to be able to predict how courts in different jurisdictions will balance the competing interests of confidentiality and public safety.

In 1980 in *Shaw v. Glickman,* the Maryland Court of Special Appeals warned that the duty to maintain confidentiality may override the duty to warn. Since the issue was not presented to the court in that case, this was not a holding but merely a dictum, a statement the court makes as a guiding principle, not as the law. Furthermore this dictum was based on a misunderstanding of the evidentiary statute. While California's statute has an exception for public safety, Maryland's does not. In *Shaw* the court used the absence of this exception as evidence of legislative policy prohibiting disclosure even where the safety of a victim is at stake. The court concluded that to warn of this danger would violate the statute. This conclusion was erroneous since the statute controls only in administrative, legislative, and judicial hearings and not in the context of the therapist's common law duties.

Psychotherapists need to be able to predict how courts in different jurisdictions will balance the competing interests of confidentiality and public safety. However the present law is unsettled in many jurisdictions. In another California case, *Mavroudis v. Kaiser Foundation Hospitals,* and in a New Jersey case, *McIntosh v. Milano,* courts held that when a therapist knows of his patient's imminent dangerousness, his duty to warn overrides his duty to maintain the confidentiality of his patient's communications.

In *Hopewell v. Adebimpe* a lower Pennsylvania court held that the confidentiality of the patient-psychotherapist relationship is absolute. Relying on a Supreme Court case, *In re Be,* the court in *Hopewell* determined that the patient had a constitutional right to confidentiality. In *In re Be* privileged information about a juvenile was requested. The court held that the information was constitutionally protected and could not be disclosed. However in that case the court was not balancing the serious threat of harm to another individual against constitutional rights. Even constitutional rights are not absolute. The

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U.S. Supreme Court has said that in times of imminent danger, even such a basic right as freedom of speech must be balanced. Thus *Hopewell* was based on a case which should have been distinguished and not followed.

In 1976 the Pennsylvania legislature passed a statute which precludes psychotherapists from disclosure of all confidential information without written consent of the patient. However in 1981 in *Leedy v. Harnett,* a federal district court applying what it believed represented the Pennsylvania Supreme Court law said, in dictum, that when there is an identifiable victim there is good reason to impose upon psychotherapists the duty to warn. The court did not mention the confidentiality statute. It is unclear whether the court in *Leedy* availed itself of the opportunity, through dictum, to read into the statute a judicially created exception or merely omitted consideration of the statute. Thus the law in Pennsylvania is still unsettled.

Since *Tarasoff,* several state legislatures have enacted statutes imposing upon psychotherapists a duty to warn of potential violent behavior of a patient, but limiting that duty to specifically defined conditions. These states include California, Colorado, Minnesota, Louisiana, and Kentucky.

Many courts have been posed questions concerning the scope of the class to whom the duty to warn is owed. In *Hedlund v. Wilson* the Supreme Court of California held that the duty to warn may extend beyond the intended victim. In that case the duty was also owed to the young child of the intended victim when that child was injured in the attack on his mother. The court found that the child was a foreseeable and identifiable victim since it was reasonable to expect a young child to be in the proximity of his mother when the attack occurred.

The Supreme Court of Iowa was presented with an interesting variant of the *Tarasoff* issue in *Cole v. Taylor.* After warning her psychiatrist of her intent, a patient fatally shot her husband. She and her subsequent husband sued the therapist for failing to take measures to prevent her. The court refused to adopt the *Tarasoff* rationale in this case holding that the duty is to the potential victim, not to the patient. Public policy would not permit recovery to a subsequent spouse.

In *Bella v. Greenson* the California Court of Appeals refused to extend the holding of *Tarasoff* to require a psychotherapist to warn third parties to take steps to prevent a suicide. There are many cases establishing a duty of a therapist to take steps to prevent a patient's suicide. Here, however, the court had to balance the breach of confidentiality against the risk of the patient's harming himself. The court did not extend the duty to warn to this situation.

In *Thompson v. County of Alameda* the California Supreme Court re-examined the duty to warn in a different context. A juvenile delinquent who had previously threatened to take the life of a young child was released to his mother's care. He then killed a child in the community. The victim's parents alleged that the county had a duty to warn the parents in the community, the police, and the mother of the juvenile delinquent. The court found that practicality limited extension of the duty to warn to protect the community. Furthermore the court held there was no duty to warn the juvenile's mother since the victim was not identifiable. The court in *Thompson* interpreted the *Tarasoff* duty to warn to require a specifically identifiable victim.

Courts and legislatures have determined that the duty to warn of a patient's dangerousness only arises when the victim is known and foreseeable. In *Doyle v. United States* a federal district court, in denying liability where no victim was identified, stated, in dictum, that in Louisiana no duty to warn had been recognized even when the victim is identifiable. This antedated the enactment by the Louisiana legislature of the statute imposing liability where the victim is clearly identified. In *Leedy v. Harnett* a federal district court held that the failure to warn did not generate liability because the plaintiffs were not the type of readily identifiable victims to whom the duty to warn ran. The hospital that released the patient knew him to be dangerous when intoxicated and knew of the likelihood of his drinking. The victims in that case were identifiable, not because the patient had threatened them, but because they were in close proximity since the patient lived with them. The court held that these were not identifiable victims under *Tarasoff* since there was merely a statistically enhanced likelihood of harm rather than an actual threat.

While there is a rational basis in the requirement of a specific identifiable victim where the duty to warn is imposed, some courts, in confusion, have required an identifiable victim where other steps to protect the public safety should have been taken. In 1983 in *Furr v. Spring Grove State Hospital,* the Maryland Court of Special Appeals stated, in dictum, that there is not only no duty to warn, but also no duty to take any steps to protect if the victim is not identified. In this case the patient, a known molester of youths, wanted by the police in connection with a homicide, was allowed to leave the grounds of the hospital where he was being evaluated. He then abducted a young boy and killed him. The court found that since there was no specific, identifiable victim there was no duty to the public. The court in *Furr* relied erroneously on the celebrated case of *Palsgraf v. Long Island R.R. Co.* which established parameters of liability. In *Palsgraf* Chief Judge Cardozo said that where a victim is foreseeable, there liability lies; but where no victim is foreseeable, there can be no liability. Chief Judge Cardozo did not restrict liability where the danger is foreseeable but the specific victim actually harmed cannot be identified. The court in *Furr* confused the foreseeable risk to an identifiable actual victim with the foreseeable risk to any potential victim.

In *Lipari v. Sears, Roebuck & Co.* the court found, under Nebraska law, that where the psychotherapist could reasonably have foreseen an unreasonable risk of harm to the class of persons of which the victims were

The psychotherapist can recognize in his patients clusters of signs, symptoms, and other factors which correlate with violence. However the psychotherapist cannot predict with certainty whether a particular individual will commit a violent act.

members, no knowledge of the identity of the victims was necessary to establish a duty to take steps to control the patient's behavior. Here the duty to warn was not at issue, and the court expressly refused to follow the limited scope of liability set forth in *Thompson* in which the duty to warn was at issue. The Supreme Court of Washington followed the *Lipari* approach in *Peterson v. State* in concluding that the psychotherapist had a duty to take steps to protect anyone who might foreseeably have been endangered by the patient's drug-related mental problems. A few other courts have recognized a duty of care under similar circumstances.

Courts and legislatures have determined that the duty to warn of a patient's dangerousness only arises when the victim is known and foreseeable.

The court in *Tarasoff* used expansive language which was ill-defined and not necessary to its holding and which has led to confusion in subsequent law. In *Tarasoff* the psychotherapist did in fact predict that his patient posed a threat of serious harm to another. The court was not presented the question of whether a therapist should have predicted dangerousness. Because of studies demonstrating the unreliability of predictions of violence, Justice Mosk objected to the court's language referring to conformity to standards of the profession for predicting violence. He objected to language that the *Tarasoff* duty arises, not only when a therapist knows of his patient's dangerous propensities, but also when he should know of such.

The careless use of language in other cases has led to confusion involving prediction of dangerousness. In *Hedlund v. Wilson* Justice Mosk, in dissent, argued that because of the lack of standards for predicting dangerousness, the duty to warn arises only when the psychotherapist has "actual knowledge" of his patient's dangerousness. He proffered "arguably" the defendant had "actual knowledge" of the patient's dangerousness because of the defendant's knowledge of the threat. Information that a patient has threatened violence does not impart knowledge or belief that the harm is likely to ensue. In *Hedlund* Justice Mosk departed from his language in *Tarasoff* where he argued that the decision rested on the circumstance that the therapist had in fact predicted the violence. Knowledge of a threat must be distinguished from "actual knowledge" of dangerousness and "in fact prediction" of dangerousness. When knowledge of a threat is confused with knowledge or prediction of dangerousness, liability is speciously extended.

In *Peterson v. State* the Washington Supreme Court concluded there was present sufficient evidence of gross negligence to find the therapist liable without explicitly basing its opinion on a finding of an actual prediction of dangerousness. The plaintiff argued that no expert witness was needed to establish a standard for prediction of dangerousness since the psychotherapist had "actual knowledge" of the patient's dangerousness. In *Peterson* a patient had been on medication for PCP induced psychosis. The psychotherapist, believing that on discharge it was unlikely that his patient would continue to take medication and it was likely that he would revert to the use of PCP and the previous violent behavior, nevertheless discharged the patient. The court seemed to find that the therapist had in fact predicted dangerousness.

Other confusing language is "diagnosing dangerousness" in *Hedlund*. Dangerousness is not a diagnosis. Dangerousness is a characteristic of some mental patients as well as in many who are not mental patients. Diagnosing is a skill of the professional; predicting dangerousness is not. The confusion of terms has led to confused and inherently wrong legal results.

Is there a standard by which the failure to predict dangerousness can be assessed and if so how is it to be determined? Because the Supreme Court of California has found psychiatrists' predictions of dangerousness to be unreliable, it requires proof beyond reasonable doubt for civil commitment. The U.S. Supreme Court has supported the use of psychiatric predictions of dangerousness in many contexts. It has held that in civil commitment, evidence of dangerousness must be demonstrated and that such evidence must be clear and convincing, a higher standard than is usually required in civil judicial determinations. Maryland, too, has a clear and convincing evidence standard for civil commitment. The Supreme Court has found the fact finder—the jury or judge—and the adversary system to be competent in

Since Tarasoff, *several state legislatures have enacted statutes imposing upon psychotherapists a duty to warn of potential violent behavior of a patient, but limiting that duty to specifically defined conditions.*

weighing psychiatric testimony of dangerousness for the purpose of imposing a death sentence.

In none of these rulings is there a need to establish a professional standard for predicting dangerousness. There is a distinction between evidence of dangerousness which a jury or judge can evaluate and evidence of a standard of reasonable care for prediction of dangerousness. In other areas of medicine a physician is held to the standard of exercising reasonable care according to his speciality. Where there is more than one school of thought, the physician may use his judgment within the broad range of reasonable practice as long as the school he follows is upheld by at least a respectable minority.

Is there a standard by which the failure to predict dangerousness can be assessed and if so how is it to be determined?

The APA, somewhat more than a respectable minority, argued in its amicus curiae brief in *Tarasoff* that psychotherapists are unable to reliably predict violent acts. This position raises distinct problems in establishing an accepted standard of reasonable practice for professional prediction of dangerousness. In *Furr* the court said that society has not yet acquired the clairvoyance to determine and restrain those bent on inflicting violence. Yet in *White v. U.S.*, the U.S. Court of Appeals for the D.C. Circuit weighed the evidence for a psychotherapist's judgment that her patient was not dangerous and found it reasonable. If, indeed, psychotherapists cannot accurately predict dangerousness, how can a court presume to evaluate expert testimony as to the reasonableness of such judgments?

The courts in *Durflinger v. Artilles* and *Bardoni v. Kim* found that reasonable standards were not met in the evaluation of patients where further inquiries would have led to determinations of dangerousness. It is not reasonable to require the same standard of investigation for every patient to insure that no sign of dangerousness is ever overlooked. A threshold determination or some generally accepted indicia of dangerousness is a prerequisite to a reasonable imposition of the duty to thoroughly evaluate, just as a prediction of dangerousness is a prerequisite to a reasonable imposition of the duty to warn. In *Jablonski v. U.S.* a psychiatrist believed his evidence of a patient's dangerousness would not support commitment and failed to obtain past records which would have supported commitment. The court found that the defendant did not perform in accordance with acceptable professional standards. Because the psychiatrist believed that his patient might be dangerous, he had a duty to investigate further.

Throughout the country in the last decade, strong public sentiment favoring safeguards against civil commitment has led to revision in criteria for involuntary admission. "Need for treatment" has generally been replaced by "dangerousness." Similarly, public policy has favored rehabilitation of dangerous criminals and an end to indeterminate sentences. These trends met a serious obstacle in the failure of psychotherapists to accurately predict dangerousness. The California legislature has provided immunity for all public officials for any damages from decisions related to commitment. In fact, in *Tarasoff*, since the psychotherapists were state employees, the court could not impose liability for failure to commit just because of this immunity and so was limited to imposing liability for failure to warn.

If, indeed, psychotherapists cannot accurately predict dangerousness, how can a court presume to evaluate expert testimony as to the reasonableness of such judgments?

Behavioral scientists have been able to identify clusters of signs, symptoms and other factors which correlate with violence. Unfortunately these same clusters are found in individuals who have never committed violent acts. Predictions based on these studies will obviously tend toward overprediction. Still, failure to take steps in light of these indications will entail the risk of the occurrence of violent acts. Because of the prevalence of these clusters in the general population, their presence in an individual cannot reasonably trigger a duty to take steps to prevent violence or to thoroughly evaluate for potential violence.

Dr. Bernard L. Diamond takes the position that declaring a person dangerous is a legal function. Psychotherapists should not be asked to do more than express their opinions as to whether a person's dangerous behavior "is a consequence of or related to, the existence of mental or emotional illness" or "whether the so-called institutional or treatment program 'medical model' is appropriate" for treatment of the condition or protection of society. By limiting the psychotherapist's role, Diamond sensibly would restrict the psychotherapist's expertise to just those areas in which he is skilled.

It is reasonable for the psychotherapist to assume a broader role, as in fact he often does, providing that role is properly defined. The psychotherapist can recognize in his patients clusters of signs, symptoms, and other factors which correlate with violence. Psychotherapists and other behavioral scientists are able to provide statistics of the incidence of violence in a sample of the general population in which these same clusters are found. These figures can be helpful in statistical predictions of dangerousness. However the psychotherapist cannot predict with certainty whether a particular individual will commit a violent act. This is consistent with the predictive use of statistics in other fields of medicine. Improving skills in recognizing factors which correlate with violence is a goal toward which future behavioral research should proceed. Dr. John Monahan criticizes the limited scope of behavioral research on violence and suggests that behavioral scientists should base prediction on a wider variety of factors. ■

The editors and authors of Treatment Trends are very interested in having you participate in making this newsletter more responsive. We invite you to send your comments, questions and ideas to: The Editor, Treatment Trends, Dept. of Community Relations, Taylor Manor Hospital, P.O. Box 396, Ellicott City, Md. 21043.

Psychiatric Commentary and References:

THE DANGEROUS PATIENT AND PSYCHIATRIC LIABILITY

By Bruce T. Taylor, M.D. and Albert A. Kurland, M.D.

The 1976 California Supreme Court ruling in *Tarasoff v. Regents of the University of California, et al* presented a clear mandate. Therapists who know or should know of a patient's dangerousness to identifiable third persons have an obligation to take all reasonable steps necessary to protect the potential victims. In this pursuit the clinician must gather the data relevant to an evaluation of dangerousness and a determination of dangerousness must be made on the basis of this data. When possible, efforts must be made to determine the identity of likely victims. Although there are substantial limits to the accuracy of such prognostications, many Tarasoff-like cases to date have not faulted therapists for inaccurate prediction but rather, for failing to gather the data that most clinicians would believe relevant to an evaluation of a person's dangerousness, Appelbaum (1985).

Dangerousness to self is another vector of legal challenge to the psychiatrist's liability. Perr (1986), a psychiatric consultant to attorneys involved in malpractice litigation in cases of suicide, has pointed out that suits involving suicide now make up 18% to 25% of malpractice cases against psychiatrists. Psychiatrists well know that a large percentage of patients have depressive symptoms; the difficult task is to differentiate those most likely to commit suicide and to formulate a meaningful treatment regimen. The issue is complicated by the low suicide rate in relation to the vast number of patients with a given diagnosis. Weed (1985) reported suicide as the eighth leading cause of death in the United States in 1982 for all ages combined, with a death rate of 12.2 suicides per 100,000 population; it was the third leading cause of death for the age groups under 35.

Perr (1986), in the analysis of the cases in which he participated, states, "the extravagant claims of some psychiatrists as experts who claimed that a different standard of care should be used and that this would prevent suicide were distressing. As in many malpractice cases, the defense was hindered by the poor quality of the records. In addition to good, consistent medical practice, adequate medical records are the most important elements in a defense of malpractice."

Recent vignettes continue to emphasize the continuing unresolved dilemma of the "dangerous" patient and psychiatric liability. A 19-year-old girl pushed a woman in front of a train at a Times Square subway station. She had been recently released by court order, against doctors' recommendations, from psychiatric treatment at Kings County Hospital Center. In Wisconsin a man barricaded himself in his house and sat with a rifle in his lap, muttering "kill, kill, kill." A judge ruled that the man was not demonstrably violent enough to qualify for involuntary commitment, Holden (1985).

Lawyers and psychiatrists have been debating these questions since the early 1970's when, in response to activism by civil libertarians, reform of involuntary civil commitment laws swept the country. Due process procedures including right to counsel, right to treatment, and limited duration of stays were installed. At the same time, the majority of states narrowed their standards for involuntary commitment, dropping the subjective criteria related to "Need For Treatment" and focusing on an individual's dangerousness to himself and others. The changes have contributed towards removing the grossest abuses: arbitrary commitments, "warehousing" with no treatment, and indeterminate hospital stays. These changes have also resulted in situations where it may be difficult to get a person who is obviously psychotic, incompetent and even suicidal—admitted for care.

Families of the mentally ill and mental health professionals have been complaining about the situation for years. In response to this need the American Psychiatric Association has proposed a new model law on involuntary civil commitment proposed by Alan A. Stone, Joint Professor at the Harvard School of Law and Medicine. The model statute would reduce the emphasis on police powers (potential dangerousness) as the main criterion by restoring the concept of "significant deterioration"—a version of the "need for treatment" standard abandoned in the civil rights movement of an earlier decade. The significant deterioration standard would permit treatment of a person who was not yet, but likely to become, gravely disabled or dangerous. The latest version of the model statute was published in the September issue of *Hospital and Community Psychiatry,* along with criticism from a variety of commentators.

Among the other complexities of psychiatric liabilities, there are the hazards faced by professionals who work in psychiatric hospitals, and treat acutely disturbed patients who have a high potential for violence. Within this context where courts have implicitly attempted to define "predictable" occurrences of violent behavior as non emergencies that would not legally justify medicating the patient against his or her will, the psychiatric professional is only too aware of the limitations of our knowledge as to the degree of reliability, accuracy, and decision making strategy in clinical predictions of imminent dangerousness, Werner et al (1983). ■

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Taylor Manor Hospital

Continuing Education Lecture Series

Location: Taylor Manor Hospital
Ruby Dining Room
Time: 7:30 p.m.

September 14, 1987

Mental Health Legislation Issues

Delegate Virginia Thomas, M.S.W., A.C.S.W.
Maryland State General Assembly

Del. Thomas will lead a discussion on some of the mental health issues before the 1988 Maryland General Assembly. What are the legislative obstacles to deinstitutionalize the mentally ill and mentally retarded? Are insurance companies and HMOs providing enough coverage for the treatment of mental illness and substance abuse? Should the licensing requirements for counselors and therapists be changed?

October 12, 1987

Affective Disorders in Children and Adolescents

Joe Coyle, M.D.
Distinguished Service Professor of Child Psychiatry
Johns Hopkins University School of Medicine

The diagnosis of affective disorders in children and adolescents is often obscured by behavioral symptoms. Dr. Coyle will discuss new clinical studies which are now identifying gene markers and linking them to the vulnerability of affective disorders.

November 16, 1987

Contemporary Trends in Mental Health Ethics

David Mills, Ph.D.
Director of the Ethics Office
American Psychological Association

Dr. Mills will focus his talk on the ethical issues surrounding professional advertising; sexual relations with patients and ex-patients; and billing practices.

Please note: ***We have changed the time of the CEU lectures from 3:00 pm to 7:30 pm. We hope this is a more convenient time for you and look forward to your participation in this excellent lecture series.***

For further information please contact the Community Relations Office—(301) 465-3322, ext. 212; Washington, D.C. (301) 621-4965, ext. 212.
These Continuing Medical Education activities are acceptable for 1 credit hour in Category 1 for the Physician's Recognition Award of the American Medical Association, and 1 elective credit hour by the American Academy of Family Physicians. Approved for Category B2(a) CE credit by the Maryland State Board of Examiners of Psychologists.
The monthly lecture series is provided at no charge as a public service of Taylor Manor Hospital. ■

Treatment Trends

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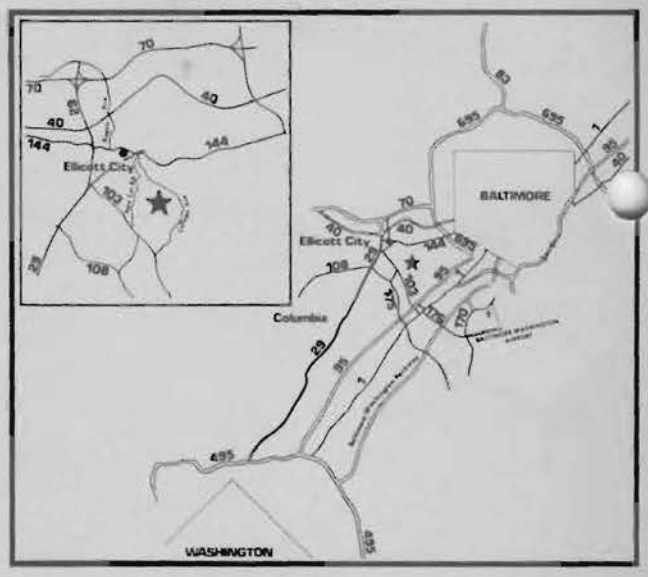
DIRECTIONS



From Points North: Take 95S to Beltway 695 to Exit 13, Route 144 W. to Ellicott City; just past R.R. Overpass, turn left at the traffic light onto Maryland Ave., follow sign and right turn onto St. Paul St., bear left onto College Ave. and follow to Taylor Manor Hospital entrance.

From Washington and Points South: Take 29N past Rt. 108. Watch for signs to Ellicott City, take right fork and go straight ahead on Old Columbia Pike. Turn right at Main St., then right at traffic light onto Maryland Ave., follow sign and right turn onto St. Paul St., bear left onto College Ave. and follow to Taylor Manor Hospital entrance.

Ample Free Parking: Parking lot is located beyond the office building, directly opposite the Psychiatric Center. Follow sign to meeting.

TAYLOR MANOR HOSPITAL
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ELLICOTT CITY, MARYLAND 21043

Continuing Education Lectures

e cordially invite you . . .

Taylor Manor Hospital is pleased to sponsor and invite you to attend a unique and exciting program:

MIND, MUSCLE AND MOTION

The medical use of therapeutic horseback riding for the psychologically and neurologically impaired.

Presenting:

Prof. Dr. med Carl Klüwer • Beth Stanford • Dr. Queenie Mills

- Dr. Klüwer, an internationally renowned psychiatrist and psychoanalyst, is one of the German physicians who began using **Hippo-therapy** as a treatment modality for emotionally and neurologically impaired patients.

  This September, Dr. Klüwer will be presenting a paper at the NIH conference on the Health Benefits of Pets. He is the international contact on Therapeutic Riding for the Federal Republic of Germany.

- Beth Stanford, pediatric N.D.T., certified physical therapist, is a board member of the North American Riding for the Handicapped Association, and lectures

around the country on the therapeutic uses of the horse. She originated the model for the riding therapy program for head trauma adults at the Bryn Mawr Rehabilitation Hospital. Beth is one of the few therapists in the U.S. trained in **Hippo-therapy.**

- Dr. Queenie Mills is the Professor Emerita of Child Development at the University of Illinois. She is a board member of the Delta Society, and has initiated several companion pet programs in Champagne, Illinois. Dr. Mills is currently active in the establishment of a center to study human-animal interaction at the University of Illinois.

HIPPO-THERAPY: a group of German doctors and therapists noted that by using telemetry, the movement components of the horse at a walk were similar to that of a normal human walking gait. The development of **Hippo-therapy** provided patients suffering from gait abnormalities with long term rhythm and neuro-motor benefits.

The role of companion pets in therapeutic environments will also be discussed in this program.

For further information and reservations, please call: Department of Community Relations, 301-465-3322, ext. #212

This Continuing Medical Education activity is acceptable for 2 credit hours in Category 1 for the Physicians Recognition Award of the American Medical Association.

Wednesday, September 9, 1987
2:00 – 4:00 p.m.
Taylor Manor Hospital • Ruby Dining Room